Building True Capacity: Indigenous Models for Indigenous Communities

Within the past 2 decades, community capacity building and community empowerment have emerged as key strategies for reducing health disparities and promoting public health. As with other strategies and best practices, these concepts have been brought to indigenous (American Indian and Alaska Native) communities primarily by mainstream researchers and practitioners.

Mainstream models and their resultant programs, however, often have limited application in meeting the needs and realities of indigenous populations. Tribes are increasingly taking control of their local health care services. It is time for indigenous people not only to develop tribal programs but also to define and integrate the underlying theoretical and cultural frameworks for public health application. (*Am J Public Health.* 2006;96:596–599. doi:10.2105/AJPH.2004.053801)

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THE CHANGING LANDSCAPE OF AMERICAN INDIAN AND ALASKA NATIVE HEALTH

Current health policies are changing perspectives on health and increasingly focusing research and program dollars on effective ways to eliminate health disparities. Along with this focus is a growing interest in the continuum of strategies for community capacity building (defined as a community's potential for responding to health issues[1]) and community empowerment as a means of mitigating both disparities and other local health concerns. Various expressions of community capacity have been integrated into indigenous (American Indian and Alaska Native) program designs, many of which have helped involve the community in responding to health disparities. However, for many tribal communities, the conceptualization and implementation of capacity-building strategies are themselves disparate in that they are based on imported Western frameworks rather than on indigenous epistemologies and indigenous "ways of knowing."[2]

Since the 1950s, the Indian Health Service has been the primary provider of federally defined health care services for American Indian/Alaska Native (AIAN) people. However, as federal funds for AIAN health diminish and health care concerns for AIAN people become increasingly complex, there has been a shift toward increasing tribal self-determination. Tribal communities are taking control of their own health services and health promotion efforts. Compacts and contracts with the Indian Health Service for tribal health care are becoming the new status quo. Anecdotal evidence from tribal leaders suggests that many tribes will benefit from this arrangement.

With this shift in the locus of power, many tribal public health professionals have looked to community mobilization, empowerment, and capacity-building models as a means of developing locally responsive programming. Different approaches to the design of tribal health programs and services are required. In addition, a change in thinking about the basic foundation upon which tribal health programs are built is needed. Indigenous people need to define and develop not only health care services but also the underlying theoretical frameworks and strategies for positive change. Tribes must be able to advocate for indigenous health in ways appropriate to the needs and realities of indigenous communities. Frameworks for developing community capacity, designed by tribal people for tribal people, would be a positive next step in indigenous health policy.

THE NEED FOR NATIVE INCLUSION

The current literature identifies various dimensions of capacity, such as participation, leadership, social supports, sense of community, access to resources, and skills, and their importance in developing and empowering local coalitions.[1,3,4] Other parallel constructs have informed the literature on community capacity, such as empowerment,[5,6] the readiness of a community to work to improve existing conditions,[7] and the social capital[8] necessary for communities to move forward and collaborate. Although these concepts support the idea of using local knowledge and local power to resolve community health disparities[1,9–11] and identify increased capacity, strategies for building capacity, and scales for measuring capacity change,[7] none has been specifically developed by or with indigenous communities.

For the most part, these discussions are taking place in environments where the voices of Native America are seldom heard. Rarely are AIAN people able to read contributions from AIAN authors or have the opportunity for an immediate, familiar frame of reference in the academic literature. Although the current constructs of capacity building are positive steps, most fail to recognize that Western definitions of success and the expected benefits to the community differ greatly from tribal expectations and definitions.[12] Western models too often assume that mainstream resources and skills exist in tribal communities and just need to be identified and defined on the community's terms.

However, such resources may not exist, and those that do exist may not fit the conceptual framework of a mainstream model.

Although some capacity-building models recognize the importance of community history,[1,13] they have yet to consider the importance of culture, language, issues of identity and place, and the need for tribal people to operate in both traditional and dominant cultures. None consider tribal sovereignty and the sociopolitical dimensions of AIAN health. Western models rarely recognize that different expressions of identity and different priorities—particularly in tribal communities—need to be part of methodology and policy as well as part of the resulting activities.[14]

There is now increasing dialogue among indigenous researchers about indigenous approaches to knowledge that contrast with Western "*ways of knowing*."[2,15–18] These concepts go beyond cultural competence and partnerships between Western institutions and indigenous community groups to what Labonte called the transformation of power relationships,[19] and to creating frameworks based on community values and indigenous perspectives not typically included in Western models.[20] Cajate,[21] for example, defined models that go beyond objective measures and honor the importance of direct experience, interconnectedness, relationship, and value. Smith[20] described an indigenous research agenda based on indigenous-centered priorities, linking self-determination with decolonization, healing, mobilization, and transformation, which suggests that indigenous people not only take charge of their own agenda but also name the processes and employ methodologies that fit indigenous framing of place, community, values, and culture.[2]

MODELS FOR TRIBAL COMMUNITIES

Tribal practitioners need a process that will engage tribal communities on their own terms, take advantage of individual skills and collective assets, focus on issues unique to AIAN people, and create effective 2-way linkages to other community initiatives and to mainstream knowledge and efforts.[3] A key consideration in the development of a tribal capacity-building model is the need for an orientation toward local health issues, which often overwhelm the limited staff and resources of tribal health programs. Public health capacity building has demonstrated value, but it is more likely to facilitate change and improvement in the long term; therefore, it is often a difficult concept for tribal communities to embrace when faced with substantial immediate need.

Another major consideration is the time needed to fully establish and integrate the capacity-building process. Mainstream models, programs, and funding agencies too often assume that tribal community members and practitioners can immediately begin to resolve an issue; they pay little attention to the social, cultural, historical, and political environment and to the time needed to build effective working relationships. The pressure to show success in tribal programs often outweighs recognition of what may have led to previous failures—the lack of sufficient time to build trust, effective communication between all participants, and inclusive working relationships.

There is still much talk by funding agencies of the need for program sustainability but limited support for the time needed to build and evaluate a foundation for long-term program success. There is also an assumption that tribal practitioners will be willing and able to use tools and instruments designed for mainstream populations and that they will have meaning in tribal communities. Further, because tribal people strive to preserve a natural balance both in nature and in life,[21] frameworks that allow for a continuum of interrelated stages to achieve natural and communal harmony and balance better than a framework with a regimented, linear format.

A tribal capacity-building model must therefore transcend the tendencies of the Western scientific community to adhere to a more linear, static, time-oriented format, which is likely to impede community involvement and discourage tribal ownership. Rather, it must establish a participatory process where mutual learning is taking place without the potential for abuses and exploitation and repair lines of trust between nonindigenous researchers and tribal communities. At the same time, however, the model must incorporate strategies for non-Native partners to raise their awareness of tribal sovereignty and community issues, ensure adherence to appropriate tribal guidelines and protocols, and become effective allies of indigenous people.

A WORKING EXAMPLE OF AN INDIGENOUS FRAMEWORK

More than a decade ago, the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention brought together a group of tribal visionaries to design a curriculum to provide training and support for community partnership programs. This group of professionals in substance abuse prevention and health education brought indigenous thought, perspective, and ownership to a national-level curriculum called the Gathering of Native Americans (GONA).[22] Their goals and philosophies ensured that the curriculum would provide training that offered hope, encouragement, skills transfer, and a positive basis for indigenous community action based on values inherent in traditional indigenous cultures. The curriculum laid the groundwork for community advocacy and community development on indigenous terms, in indigenous ways, for indigenous people.

From this model and their experiences as GONA facilitators, 3 American Indian, community-based public health and research professionals (Joyce Naseyowma, Michelle Chino, and Connie Garcia) working for a tribal consortium in the Southwest developed the Community Involvement to Renew Commitment, Leadership, and Effectiveness (CIRCLE). The CIRCLE is a 4-step, cyclical, iterative process and philosophy for program design and community development for indigenous people. The CIRCLE incorporates Western concepts of community capacity building and parallels the values of community-based participatory research.[23] Both the philosophy and method, however, go beyond the assumptions and methods of most mainstream approaches.

At its core, the CIRCLE process posits that, as personal and professional relationships develop, they lead to the development of individual and group skills. These skills in turn lead to

effective working partnerships, ultimately promoting a commitment to the issue, the group, and the process. This process creates an interest in new relationships, the need for new skills, and new opportunities for collaboration and a long-term commitment to positive change. Rooted in indigenous ideology, this model exemplifies the type of capacity-building framework that can work well in tribal communities.

The 4 steps of the model are flexible and can be adjusted according to the time and effort needed for each. The first step—*building relationships*—honors the GONA concept of "belonging" and represents infancy and childhood, a time when people need to know they belong and are important. The focus is on establishing open communication and identifying common ground and common goals—a first step toward working together effectively. The second step—*building skills*—honors the GONA concept of "mastery" and represents adolescence, a time when people learn what their capabilities are and how they can make individual contributions that are unique and valuable to the process. This step allows participants to develop both interpersonal skills and practical skills such as group decisionmaking.

The third step—*working together*—honors the GONA concept of "interdependence" and represents adulthood and one's interdependence with family, culture, environment, and the social, political, and historical framework of the community. For indigenous people, it is important to integrate the tradition of community and reinforce the notion that groups become stronger and more effective when they can solve problems together. The fourth step—*promoting commitment*—honors the GONA concept of "generosity" and represents elders, who give their knowledge and teaching to generations of the future. It is a time when participants examine their responsibility to give back to their families and communities as advocates and mentors.

Although many of these elements are recognized by the Western scientific community and parallel other capacity-building models, part of what makes this approach different is the time devoted to the first step and the primary focus on the content of the second step. Relationship building is an essential process in tribal communities, one that is deeply embedded in history and context. This process also allows for creative skills development and individual strengths and interests. The model goes beyond the surface structure of cultural competence to the deeper structure of the cultural, historical, social, and environmental forces that shape health behaviors among indigenous people.[24] Its origins, its priorities, and its intricate connection to traditional concepts of the cycles of indigenous lives are easily embraced and readily understood by indigenous people.

The process has demonstrated flexibility, is replicable, can be evaluated, and can be tailored to any concern, situation, or population. Since the early 1990s, this approach has been well received by tribal communities in the Southwest and has served as a framework for responding to an array of indigenous health issues, including intimate partner violence, cancer, and health disparities (Table 1). Despite the fairly substantial number of federally funded and evaluated programs incorporating the CIRCLE, there has been little recognition of the process as a model per se.[25]

IMPLICATIONS FOR HEALTH POLICY AND PRACTICE

Capacity building for indigenous people needs to go beyond "action planning" and "engaging leadership," concepts that are often the first steps in Western models. Before indigenous people can effectively engage in building healthier communities, the wounds caused by colonization, historical trauma, racism, and disparities in health, education, and living conditions need to be acknowledged, treated, and healed. There needs to be a positive collective identity, with trust for each other and for the process. A mechanism is needed for building the essential skills the Western scientific community may take for granted and, conversely, for educating the Western scientific community about

TABLE 1—Programs Incorporating the CIRCLE Framework, by Organization, Years, and Funding Source

Program Name	Organization	Years	Funding Source
Rural Domestic Violence and Child Victimization Prevention in American Indian Communities	Albuquerque Area Indian Health Board Inc, Albuquerque, NM	1993–1996	US Dept of Justice, Violence Against Women Grants Office
Evaluation of a Domestic Violence Prevention Program for American Indians	Family Harmony Program, Tuba City, Ariz	1995	Navajo Nation
Building Community Capacity to Address Breast and Cervical Cancer Among American Indians: A REACH 2010 Project	Albuquerque Area Indian Health Board Inc, Albuquerque, NM	2000–2007	USDHHS, Centers for Disease Control and Prevention
Project EXPORT: Building Capacity for Health Disparities Research at UNLV	UNLV Center for Health Disparities Research, Las Vegas, Nev	2004–2007	National Institutes of Health, National Center for Minority Health and Health Disparities

Note. CIRCLE = Community Involvement to Renew Commitment, Leadership, and Effectiveness; USDHHS = US Department of Health and Human Services; UNLV = University of Nevada at Las Vegas.

Native science[21] and indigenous "ways of knowing." Indigenous people need to come together in a way that is comfortable, familiar, and respectful of different cultures and traditions.

An indigenous model must reflect indigenous reality. It must integrate the past, the present, and the people's vision for the future. It must acknowledge resources and challenges and allow communities to build a commitment to identifying and resolving health concerns and issues.

Further, by using an indigenously developed and tested model, the common and often unconscious tendency of public health officials and politicians worldwide to use images and stereotypes of "culture" to deflect blame away from inadequate policies, institutions, and public health infrastructures and onto oppressed people themselves can be avoided. An indigenous model works from the "ground up," reversing the top-down application of Western science to classic public health that too often results in programs that are "outside-in" and "community placed," rather than community based (see Goodman et al.[1] for this distinction).

To face social inequality honestly requires an ecological approach in which health disparities are viewed as a failure of institutional systems, policies, and perspectives rather than the fault of the victims of those disparities. As Briggs and Mantini-Briggs so aptly stated,

> We must challenge the objectification of images of social inequality in epidemiology, demography, and social science. We must insist on keeping images of inequality closely linked to the social, political and historical circumstances in which they were produced. . . . Insight into the way that this process works to the detriment of all parties can help persons on the privileged side of a social divide be more responsible to those on the other side who are struggling to overcome structural violence and achieve social justice.[26(p327)]

Although mainstream professionals struggle to become culturally competent in tribal health matters, indigenous health professionals struggle to become competent in meeting the demands of mainstream funding sources and mainstream standards for practitioners and programs. Finding a link between what works for tribal programs and what is acceptable to outside sources is a constant challenge. Indigenous models can bring indigenous people and nonindigenous partners together by offering a relevant, meaningful framework where cultural and institutional barriers fade. Every person can then engage in the process of promoting and developing natural skills and abilities so that all participants become competent in their efforts, enjoy the process, and benefit from the outcomes. ■

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This commentary was accepted February 17, 2005.

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M. Chino originated the article and led the writing. L. DeBruyn assisted with the conceptualization and framing of ideas, contributed to the writing, and reviewed drafts of the article.

Acknowledgments

We thank Theda New Breast Ramos, John Bird, Cecilia Fire Thunder, Terry Tafoya, Patricia Martin, Gene Giron, JoAnn Kauffman, and Catherine Reimer, the creators of the GONA; Connie Garcia and Joyce Naseyowma, codevelopers of the CIRCLE framework; all those who have used and shared the model; and Kevin English, Bob Goodman, and Nina Wallerstein for their contributions and insights.

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